MARYLAND
DUALS CARE DELIVERY WORKGROUP

FEBRUARY 29, 2016 | 1:00-4:00 PM

AGENDA

- Welcome & Introductions
- Review of Data on Dual Eligibles in Maryland
- Review Other CMS/State Programs Focused on Dual Eligibles
- Existing Maryland Efforts and Projects Impacting Dual Eligibles
- Design Considerations for Maryland's Duals Initiative
- Next Steps
- Public Comment

VISION AND GOALS OF THE PROJECT

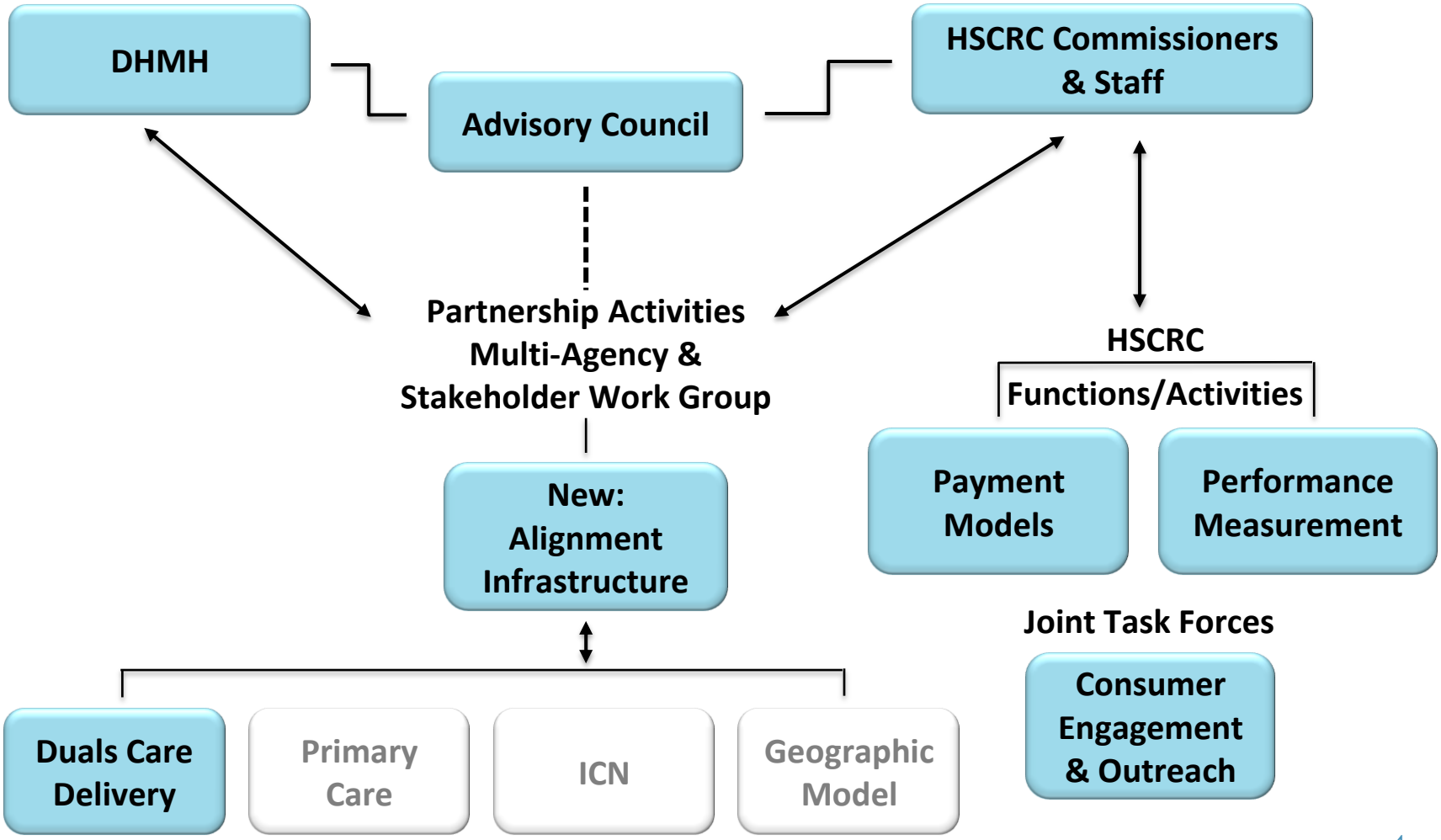
DHMH's focus on dual eligibles is based on the consensus that was achieved through the Advisory Council and multiple workgroups that full duals should be a top priority

- Maryland stakeholders identified dual eligibles as a population with substantial health and social support needs who are largely unmanaged in the current delivery system
- The focus on duals reflects the fact that new models of care for these beneficiaries have not been systematically identified

DHMH, aided by EBG Advisors, will continue to develop a Duals Care Delivery strategy in collaboration with other state and federal partners and guided by the Duals Care Delivery Workgroup. The work will address:

- *The governance model.*
- *The beneficiary attribution process.*
- *The provider attribution/alignment process.*
- *Accounting for total cost of care.*
- *Development of quality metrics and incentives.*

EMERGING STAKEHOLDER ENGAGEMENT STRUCTURE



WORKGROUP'S PURPOSE

The purpose of the Duals Care Delivery Workgroup is to facilitate multi-stakeholder discussions regarding efficient and effective implementation of the dual eligible program design that supports CMMI's goals and DHMH's goals. They are:

Improve the patient experience, improve the health of populations, and reduce the growth in per capita costs of health care

- Alignment: Promote value-based payment
- Care Delivery: Increase integration and coordination
- Health Information Exchange and Tools: Support providers

WORKGROUP MEMBERS

- Alzheimer Association, Maryland
- Amerigroup
- CareFirst BlueCross BlueShield
- CRISP
- Dorchester County Addictions Program - National Council on Alcoholism and Drug Dependence
- Erickson Living
- Health Facilities Association of Maryland
- Johns Hopkins HealthCare
- Maryland Department of Aging
- Maryland Health Care for All Coalition
- Maryland Hospital Association
- Maryland Learning Collaborative
- MedChi
- MedStar Health
- Mental Health Association of Maryland
- Mid-Atlantic Association of Community Health Centers
- Mid-Atlantic Healthcare
- Mosaic Inc.
- Schwartz, Metz & Wise
- Talbot County
- The Coordinating Center
- Towson University
- University of Maryland
- Way Station Inc./
  Sheppard Pratt Health Systems

MARYLAND FULL-BENEFIT DUALS

DEMOGRAPHICS, DISEASE CATEGORIES, COSTS AND UTILIZATION

SELECTED CHARACTERISTICS OF MARYLAND FULL-BENEFIT DUAL-ELIGIBLE BENEFICIARIES, BY AGE GROUP, CY 2012

	All Ages*	Under 65	65 and Older
Total	**88,150**	**39,726**	**48,424**
Gender			
Male	38%	57%	43%
Female	62%	38%	62%
Race			
Asian	7%	8%	92%
Black	39%	53%	47%
White	42%	50%	50%
Hispanic	3%	24%	76%
Native American	<1%	60%	40%
Pacific Islands/Alaskan	<1%	30%	70%
Unknown	9%	25%	75%
Region			
Baltimore/Washington Metro	80%	44%	56%
Eastern Shore	9%	50%	50%
Southern Maryland	4%	48%	52%
Western Maryland	7%	49%	51%
Out of State	<1%	50%	50%

***** Due to rounding, percentages do not equal 100%.

Source: MMIS2

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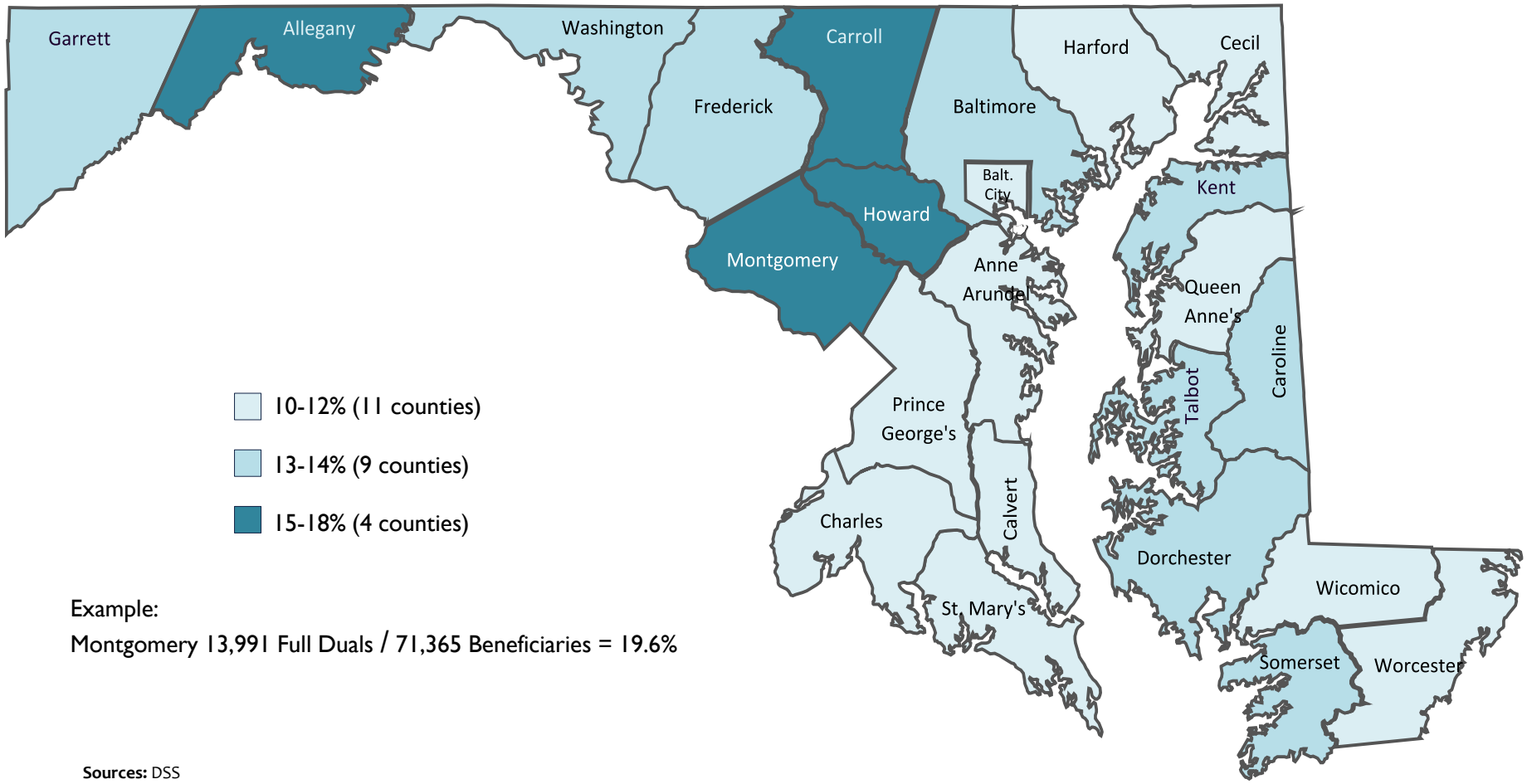
CHARACTERISTICS OF NEW AND CONTINUOUSLY ENROLLED FULL-BENEFIT DUAL-ELIGIBLE BENEFICIARIES, CY 2012

	All		New in CY 2012		Continuously Enrolled	
	Number	Percentage	Number	Percentage	Number	Percentage
Age						
Under 65	39,726	45%	4,128	55%	35,437	44%
65 and Older	48,424	55%	3,374	45%	44,988	56%
Pathway						
Medicare First	✦61,953	70%	1,450	19%	60,501	75%
Medicaid First	24,198	28%	5,738	76%	18,460	15%
Simultaneous	1,777	2%	314	4%	1,463	2%
Original Reason for Medicare						
Age	40,751	46%	3,347	45%	37,374	46%
Disability	✦45,566	52%	3,937	52%	41,627	52%
ESRD	968	1%	192	3%	776	1%
Both Age and Disability	674	1%	26	0%	648	1%

Note: The Medicare buy-in indicator was used to determine new or continuous enrollment status.
Source: MMIS2

FULL-BENEFIT DUAL-ELIGIBLE BENEFICIARIES AS A PERCENTAGE OF MEDICAID BENEFICIARIES AGED 16 AND OLDER, BY COUNTY, CY 2012

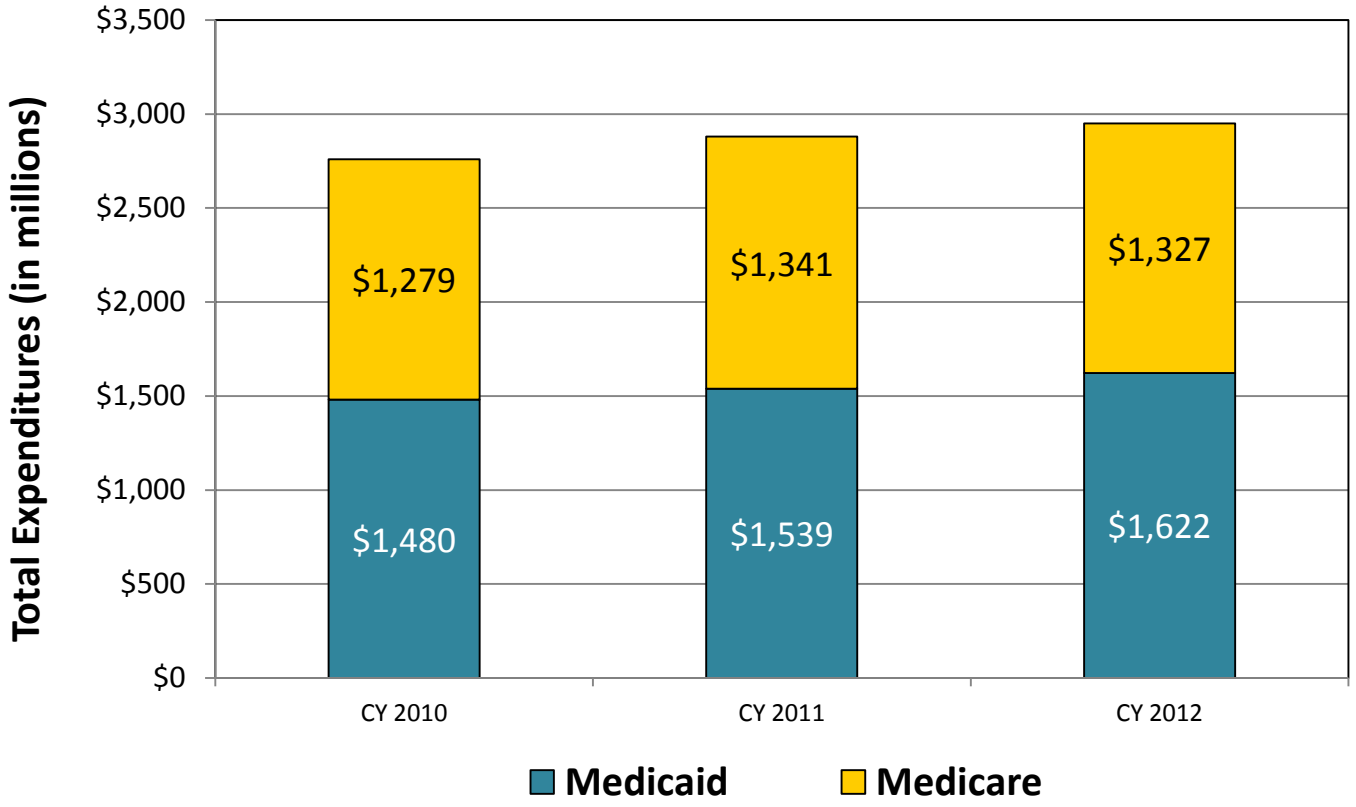


Example:
Montgomery 13,991 Full Duals / 71,365 Beneficiaries = 19.6%

Sources: DSS

The Hilltop Institute

TOTAL MEDICARE AND MEDICAID EXPENDITURES FOR FULL-BENEFIT DUAL-ELIGIBLE BENEFICIARIES, BY PAYER, CY 2010 – 2012



Note: All dual-eligible Medicare and Medicaid expenditure charts include fee-for-service expenditures only (i.e., excludes HealthChoice, Medicare Part D, and Medicare Advantage expenditures). Non-dual-eligible expenditure include Medicaid fee-for-service expenditures and managed care organization capitation payments (Medicare premium payments are not included in MMIS2 data).

Source: MMIS2

TOTAL, AVERAGE ANNUAL AND PMPM EXPENDITURES FOR FULL-BENEFIT DUAL ELIGIBLES, BY PAYER, CY 2010-2012

CY	Program	All Ages		
		Total Expenditures	Average Cost Per Person Per Year	PMPM
2010	Medicare	$1,278,948,512	$18,360	$1,709
	Medicaid	$1,480,361,279	$21,251	$1,978
2011	Medicare	$1,341,200,263	$18,497	$1,736
	Medicaid	$1,538,940,244	$21,225	$1,993
2012	Medicare	✦ $1,326,935,634	$17,625	✦ $1,641
	Medicaid	✦ $1,622,444,159	$21,550	✦ $2,006

Source: MMIS2

Total Medicaid expenditures for full-benefit dual-eligible beneficiaries increased 10%, from $1.48 billion in CY 2010 to $1.62 billion in CY 2012.

Medicare expenditures grew at a slower rate of 4% during this period. In each of the reporting periods, on average, Medicaid paid slightly more per person per year than did Medicare.

AVERAGE ANNUAL AND PMPM MEDICARE AND MEDICAID EXPENDITURES, BY AGE GROUP, CY 2010-2012

	CY 2010		CY 2011		CY 2012	
	Average Annual Expenditures Per Person	Total Expenditures PMPM	Average Annual Expenditures Per Person	Total Expenditures PMPM	Average Annual Expenditures Per Person	Total Expenditures PMPM
Under Age 65	$36,087	$3,279	$34,880	$3,186	$35,148	$3,192
Age 65 and Older	$42,619	$4,051	$44,044	$4,240	✦$42,632	$4,057
Total	$39,611	$3,687	$39,722	$3,729	$39,175	$3,647

Source: MMIS2

DISTRIBUTION OF FULL-BENEFIT DUAL-ELIGIBLE MEDICARE AND MEDICAID EXPENDITURES, BY SERVICE CATEGORY, CY 2012

SERVICE	Medicaid Expenditures	Percentage of Medicaid Expenditures	Medicare Expenditures	Percentage of Medicare Expenditures	Total Expenditures	Percentage of Total Expenditures
Dental	$121,004	<1%	$0	<1%	$121,004	<1%
Durable Medical Equipment	$385,725	<1%	$32,917,711	2%	$33,303,437	1%
Home Health Services*	$642,478,730	✦ 40%	$28,625,905	2%	$671,104,636	23%
Hospice	$21,928,227	1%	$30,334,906	2%	$52,263,133	2%
Inpatient	$49,440,570	3%	$574,994,940	✦ 43%	$624,435,510	21%
Outpatient/Carrier	$136,000,050	8%	$502,592,047	✦ 38%	$638,592,097	22%
Pharmacy	$8,025,303	<1%	$0	<1%	$8,025,303	<1%
Nursing Facility	$734,315,146	✦ 45%	$157,470,123	12%	$891,785,270	30%
Special Programs	$29,749,404	2%	$0	<1%	$29,749,404	1%
Total	**$1,622,444,159**	**100%**	**$1,326,935,634**	**100%**	**$2,949,379,794**	**100%**

* Includes Medicare home health services and Medicaid state plan and home and community-based waiver personal care services.

Notes: Medicare pharmacy expenditures do not include Medicare Part D claims. Medicaid may cover some prescription costs. Medicare does not cover most dental care, dental procedures, or supplies. Medicare Part A (Hospital Insurance) will pay for certain dental services performed while in the hospital.

Source: MMIS2

DISTRIBUTION OF FULL-BENEFIT DUAL-ELIGIBLE MEDICARE AND MEDICAID EXPENDITURES, BY SERVICE CATEGORY AND AGE GROUP,* CY 2012

Service	Under Age 65		Age 65 and Older		All Ages
	Medicaid	Medicare	Medicaid	Medicare	Total
Dental	$120,256	$0	$748	$0	$121,004
Durable Medical Equipment	$194,972	$17,805,105	$190,753	$15,112,607	$33,303,437
Home Health Services**	$431,582,678	$8,531,164	$210,896,052	$20,094,741	✦$671,104,636
Hospice	$2,527,648	$3,568,189	$19,400,579	$26,766,718	$52,263,133
Inpatient	$28,233,306	✦$234,660,400	$21,207,264	✦$340,334,541	✦$624,435,510
Outpatient/Carrier	$97,896,334	✦$242,550,983	$38,103,716	✦$260,041,064	✦$638,592,097
Pharmacy	$3,075,722	$0	$4,949,582	$0	$8,025,303
Nursing Facility	$109,014,507	$32,158,854	✦$625,300,640	$125,311,270	✦$891,785,270
Special Programs	$10,566,295	$0	$19,183,108	$0	$29,749,404
Total	**$683,211,716**	**$539,274,694**	**$939,232,443**	**$787,660,940**	**$2,949,379,794**

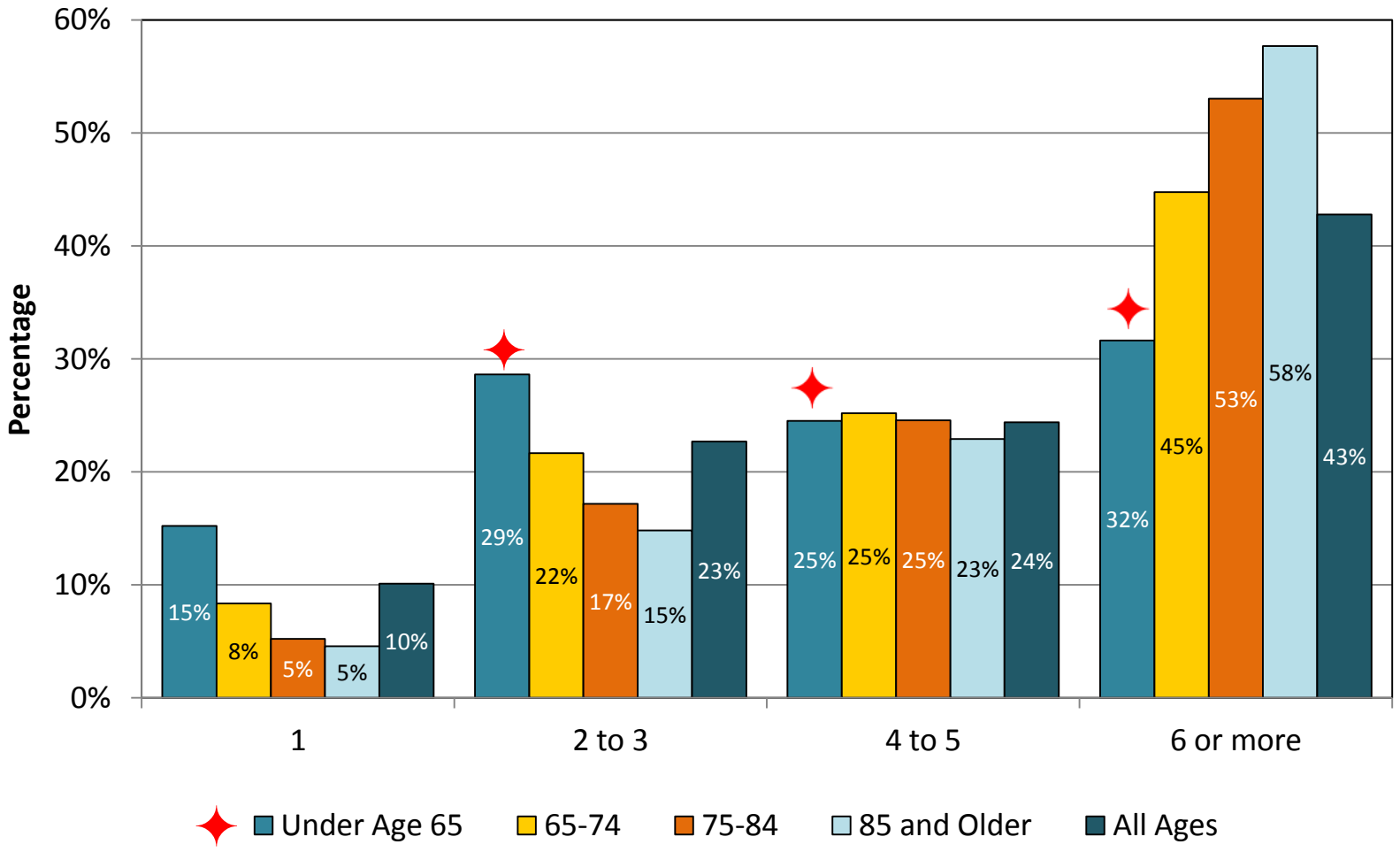
*Expenditures for dual-eligible beneficiaries with no available age are excluded from this analysis.

** Includes Medicare home health services and Medicaid state plan and home and community-based waiver personal care services.

Note: Pharmacy expenditures do not include Medicare Part D claims. Medicaid may cover prescription costs. Medicare does not cover most dental care, dental procedures, or supplies. Medicare Part A (Hospital Insurance) will pay for certain dental services performed while in the hospital.

Source: MMIS2

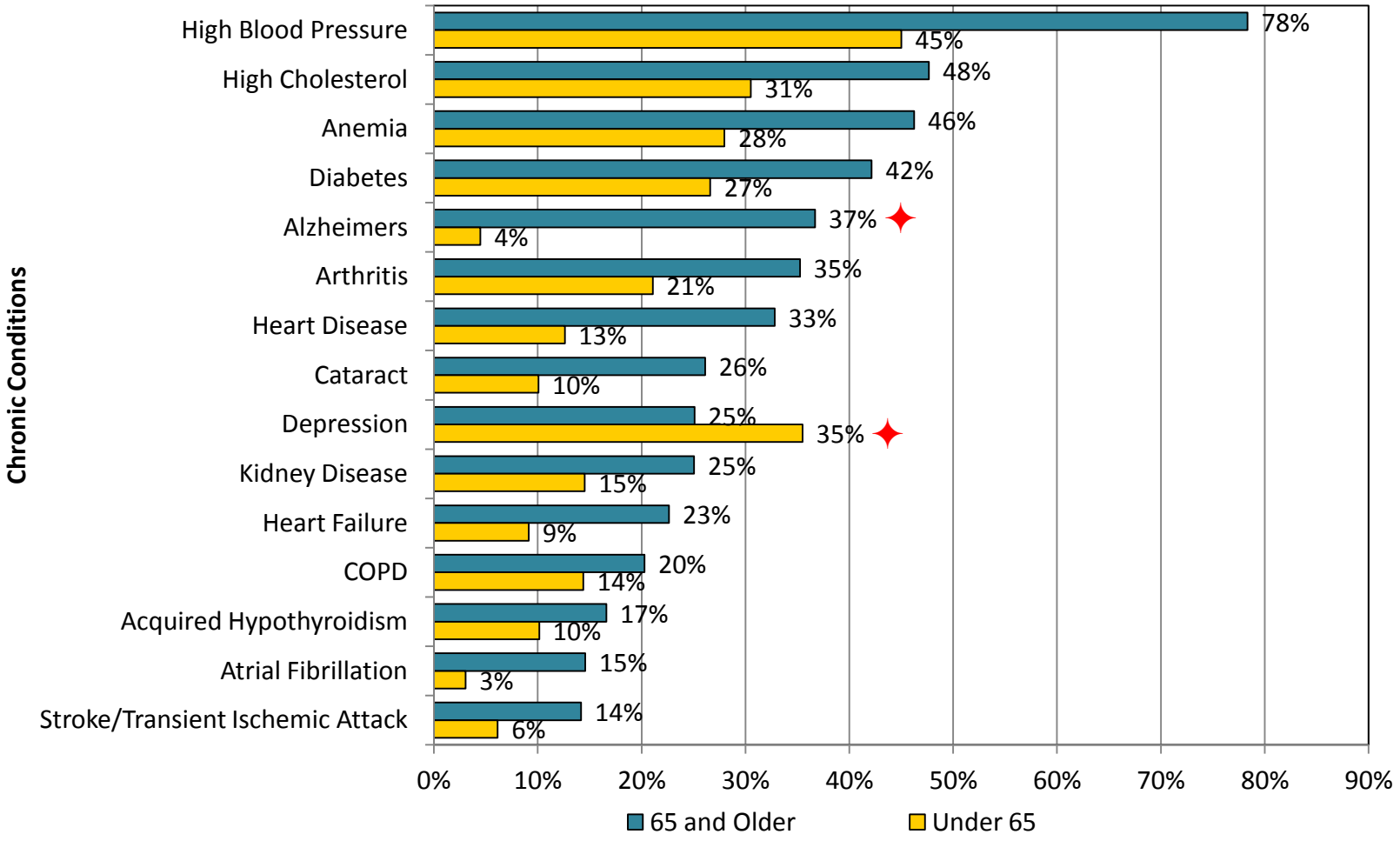
PERCENTAGE OF FULL-BENEFIT DUAL-ELIGIBLE BENEFICIARIES, BY NUMBER OF CHRONIC CONDITIONS AND AGE GROUP, CY 2012



Sources: MMIS2, Medicare claims

The Hilltop Institute

PERCENTAGE OF FULL-BENEFIT DUAL-ELIGIBLE BENEFICIARIES WITH SELECTED CHRONIC CONDITIONS, BY AGE GROUP, CY 2012



Sources: MMIS2, Medicare Claims

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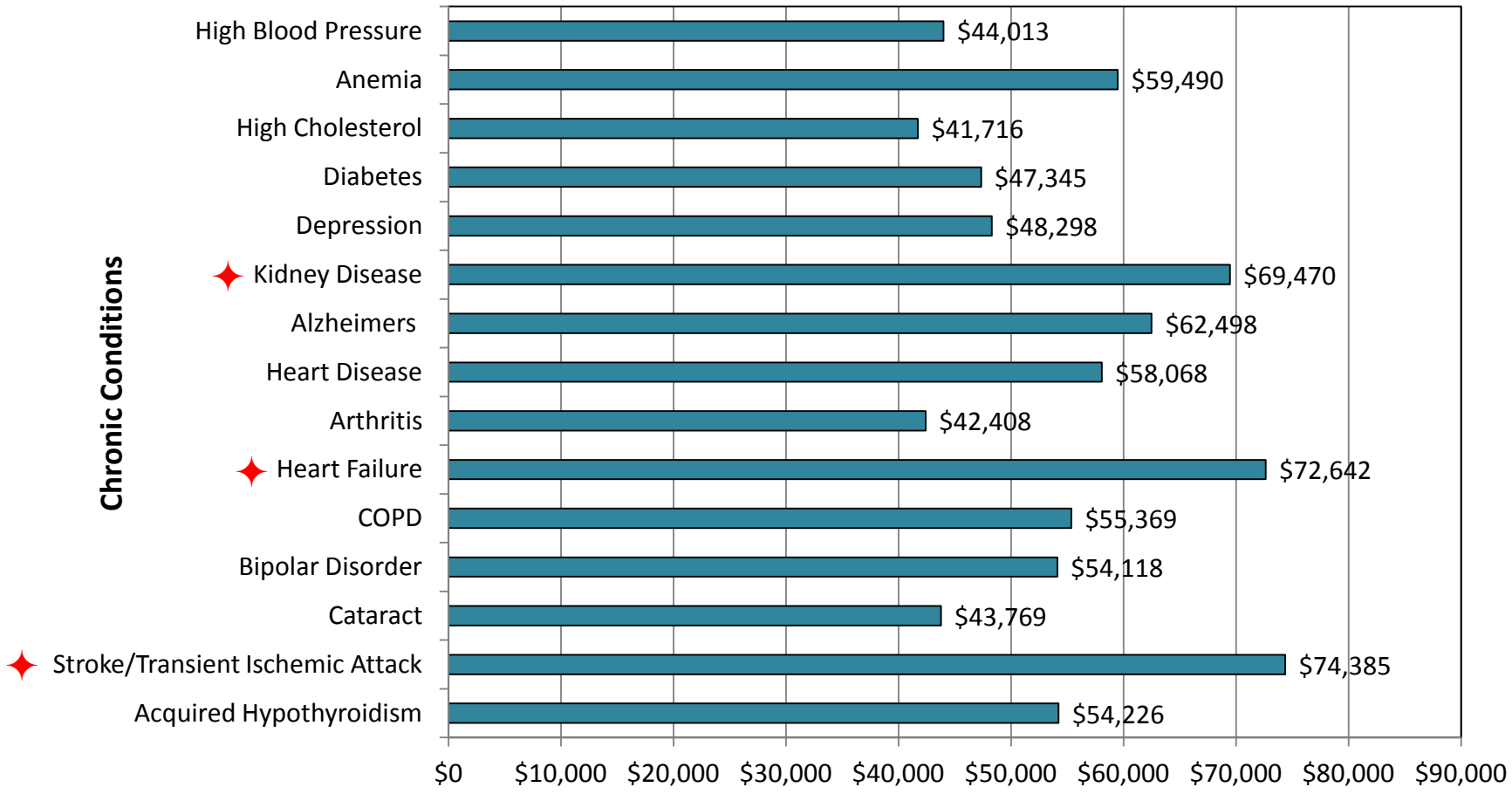
AVERAGE MEDICARE AND MEDICAID EXPENDITURES, BY TYPE OF CHRONIC CONDITION, CY 2012



Sources: MMIS2, Medicare Claims

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PER CAPITA MEDICARE AND MEDICAID EXPENDITURES, BY CHRONIC CONDITION DYADS, CY 2012

Chronic Condition Dyads	Prevalence	Per Capita Costs*
Age 65 and Older		
High Cholesterol, High Blood Pressure	42.2%	$45,666
Diabetes, High Blood Pressure	35.7%	$55,353
Anemia, High Blood Pressure	39.3%	$66,304
High Blood Pressure, Arthritis	29.2%	$51,387
High Blood Pressure, Heart Disease	29.7%	$64,005
Under Age 65		
High Cholesterol, High Blood Pressure	23.9%	$49,699
Diabetes, High Blood Pressure	21.9%	$59,487
Anemia, High Blood Pressure	19.7%	$79,105
High Blood Pressure, Depression	18.9%	$58,270
Bipolar Disorder, Depression ✦	16.2%	$45,186

*Per capita expenditures do not include Medicare Part D Claims.

Sources: MMIS2, Medicare Claims

The Hilltop Institute

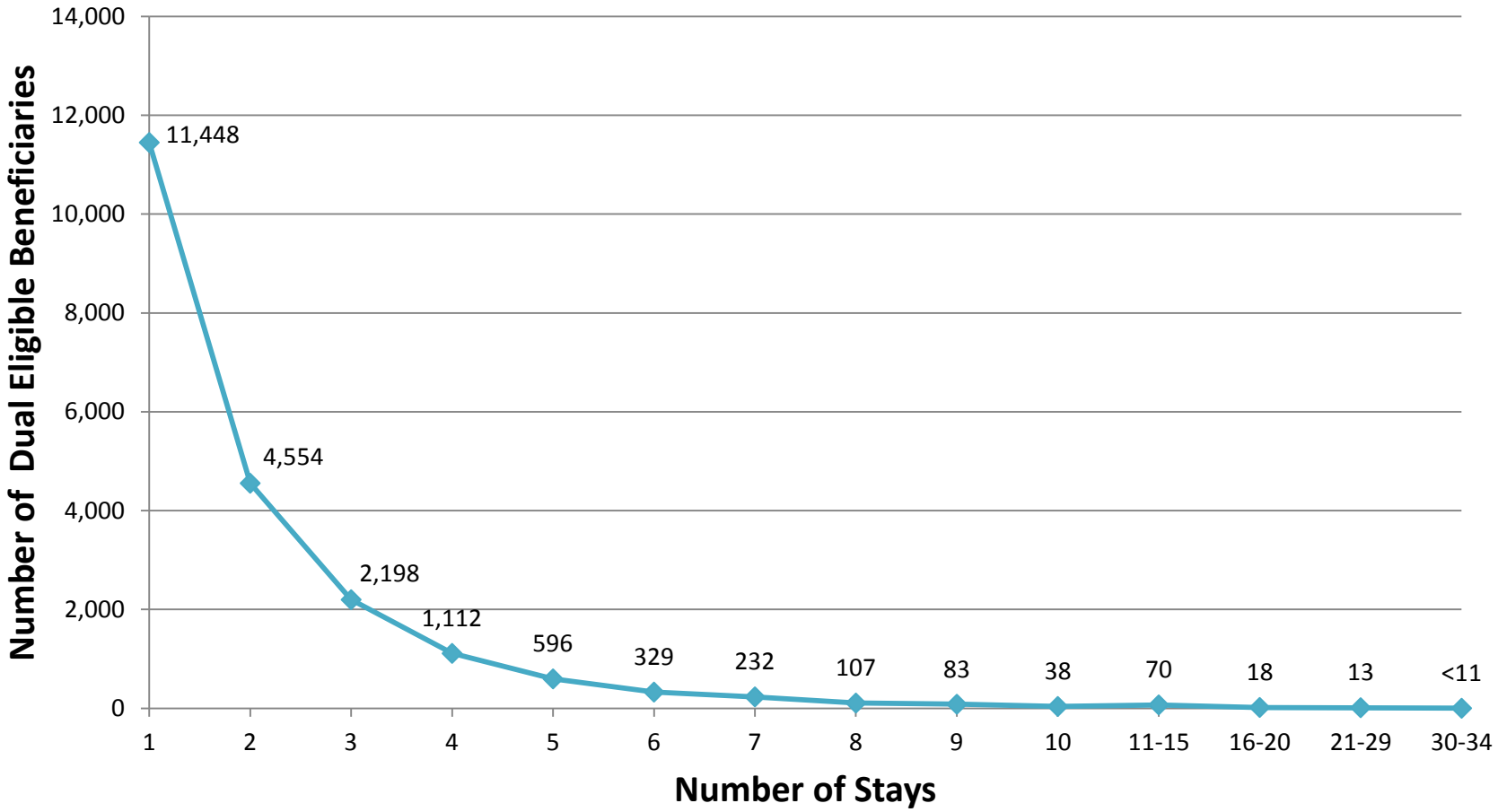
TOP 5 MEDICARE SEVERITY DIAGNOSIS-RELATED GROUPS

Diagnosis-Related Group	All Ages		Under 65		Age 65 and Older	
	N	%	N	%	N	%
Psychosis	2,050	6%	1,715	11%	335	2%
Septicemia or Severe Sepsis*	1,749	5%	516	3%	1,233	6%
Kidney and Urinary Tract Infections**	970	3%	166	1%	804	4%
Heart Failure and Shock*	715	2%	251	2%	464	2%
Simple Pneumonia and Pleurisy*	681	2%	207	2%	474	1%

NOTE: Excluded from this table is an unidentifiable DRG that was assigned 3.24% of stays

* With major complications or comorbidities
** Without major complications or comorbidities

NUMBER OF HOSPITAL STAYS BY COUNT OF FULL-BENEFIT DUAL ELIGIBLE BENEFICIARIES, CY 2012



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PRE-STAY SETTINGS, BY AGE GROUP, CY 2012

Pre-Stay Setting	All		Under 65		65 and Older	
	N	%	N	%	N	%
Medicare ED Visit	32,724	88% ✦	12,739	85%	19,985	91%
Medicare Hospice	138	<1%	27	<1%	111	<1%
Medicare Home Health Agency	1,090	3%	346	2%	744	3%
Medicare Skilled Nursing Facility	4,148	11%	976	6%	3,172	14%
Medicare Inpatient Stay ✦	4,516	12%	2,099	14%	2,417	11%
Medicaid Home and-Community Based Services ✦	5,907	16%	2,265	15%	3,642	17%
Medicaid Nursing Facility	3,470	9%	637	4%	2,833	13%
No Previous Service	2,914	8%	1,705	11%	1,209	5%

Source: Medicaid and Medicare eligibility and claims data, CY 2012.

POST-STAY SETTINGS, BY AGE GROUP, CY 2012

Post-Stay Setting	All		Under 65		65 and Older	
	N	%	N	%	N	%
Medicare ED Visit ✦	11,893	32%	5,884	39%	6,009	27%
Medicare Hospice	1,454	4%	224	1%	1,230	6%
Medicare Home Health Agency	4,771	13%	1,602	11%	3,169	14%
Medicare Skilled Nursing Facility ✦	12,393	33%	2,630	18%	9,763	44%
Medicare Inpatient Stay ✦	10,159	27%	4,644	31%	5,515	25%
Medicaid Home and-Community Based Services	5,500	15%	2,251	15%	3,249	15%
Medicaid Nursing Facility	5,092	14%	1,053	7%	4,039	18%
No Post-Stay Service	6,420	17%	3,807	25%	2,613	12%
Died	2,809	8%	530	4%	2,279	10%

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Source: Medicaid and Medicare eligibility and claims data, CY 2012.

POST-STAY SERVICE, BY PRE-INPATIENT STAY SERVICES, CY 2012

Pre-Stay Service	Medicaid Post-Stay Services			Medicare Post-Stay Services					Other	
	HCBS	Hospice	NF	ED	Home Health	Hospice	Inpatient	SNF	No Post Services	Died
Medicaid HCBS	✦87%	0%	1%	30%	20%	4%	25%	21%	1%	7%
Medicaid Hospice	0%	57%	50%	22%	0%	59%	17%	29%	0%	28%
Medicaid NF Stay	0%	5%	✦59%	22%	0%	8%	22%	49%	1%	19%
Medicare ED Visit	15%	2%	14%	35%	12%	4%	28%	34%	16%	8%
Medicare Home Health	17%	1%	5%	39%	19%	6%	33%	50%	6%	12%
Medicare Hospice	7%	23%	23%	28%	4%	54%	22%	28%	1%	27%
Medicare Inpatient	12%	2%	10%	✦79%	14%	4%	✦42%	39%	3%	10%
Medicare SNF Stay	3%	3%	27%	43%	5%	7%	32%	✦78%	1%	17%
No Previous Service	0%	0%	2%	6%	10%	0%	10%	9%	19%	1%

Source: Medicaid and Medicare eligibility and claims data, CY 2012.

Caution: Percentages can sometimes be associated with low sample size

MEDICARE EXPENDITURES FOR FULL-BENEFIT DUAL ELIGIBLES WITH 3 OR MORE INPATIENT STAYS, BY SERVICE TYPE AND AGE GROUP, CY 2012

Service Type	Expenditures for Dual Eligibles Under Age 65	Percentage of Total Expenditures	Expenditures for Dual Eligibles Aged 65 and Older	Percentage of Total Expenditures
Medicare Expenditures				
Carrier	$27,949,308	12.8%	$36,806,420	11.9%
DME*	$3,478,863	1.6%	$2,818,629	0.9%
Home health aide	$3,278,667	1.5%	$7,055,113	2.3%
Hospice	$713,134	0.3%	$2,346,782	0.8%
Inpatient	$136,536,350	✦62.4%	$185,335,068	✦60.0%
Outpatient	$30,816,006	14.1%	$25,276,301	8.2%
Nursing Facility	$16,013,468	7.3%	$49,407,469	16.0%
Total Medicare	**$218,785,796**	**100.0%**	**$309,045,782**	**100.0%**
Total Medicaid & Medicare Expenditures	**$277,206,089**		**$375,265,710**	✦**$652,471,799**

*Durable Medical Equipment

"Carrier" services are defined under Medicare Part B as primarily professional providers' services (e.g. physicians and other medical professional) along with outpatient therapy services and the carrier category under Medicaid is constructed from a similar set of claims.

MEDICAID EXPENDITURES FOR FULL-BENEFIT DUAL ELIGIBLES WITH 3 OR MORE INPATIENT STAYS, BY SERVICE TYPE AND AGE GROUP, CY 2012

Service Type	Expenditures for Dual Eligibles Under Age 65	Percentage of Total Expenditures	Expenditures for Dual Eligibles Aged 65 and Older	Percentage of Total Expenditures
Medicaid Expenditures				
DME*	$53,577	0.1%	$21,642	0.0%
Home health aide	$9,558	0.0%	$16,386	0.0%
Nursing facility	$12,899,022	22.1%	$34,627,838	✦52.3%
Carrier	$7,418,141	12.7%	$3,534,503	5.3%
Dental	$10,127	0.0%	$58	0.0%
Home health services	$14,925,539	25.5%	$14,578,185	✦22.0%
Hospice	$169,690	0.3%	$233,562	0.4%
Inpatient	$15,605,799	26.7%	$8,085,251	✦12.2%
Long term care	$319,065	0.5%	$355,244	0.5%
MCO Capitation	$1,431,396	2.5%	$360,309	0.5%
Outpatient	$3,717,439	6.4%	$2,319,414	3.5%
Pharmacy	$552,019	0.9%	$347,619	0.5%
Special services	$1,308,920	2.2%	$1,739,917	2.6%
Total Medicaid	**$58,420,293**	**100.0%**	**$66,219,928**	**100.0%**
Total Medicaid & Medicare Expenditures	**$277,206,089**		**$375,265,710**	✦**$652,471,799**

*Durable Medical Equipment

The "special services" classification of Medicaid claims include services not captured under other categories, such as laboratory testing, transportation, and other social support services.

OTHER DUALS PROGRAM MODELS

ILLUSTRATIVE PROGRAM DESIGNS

ARRAYING GENERIC DESIGNS

Fee-for-Service (FFS)	
Unmanaged	Managed

- No enrollment
- Beneficiary not directed to any provider
- No risk transferred
- Managed FFS features care coordination

Accountable Care Organizations (ACOs)	
Savings Only	2-Way Risk

- Beneficiary attributed to ACO, not enrolled
- Beneficiary free to use any provider
- Risk shared with payer against cost of care target
- Care coordination/ management may be attempted

Managed Care Organizations (MCOs)	
Coincidental Medicaid MCOs & Medicare MCOs	Integrated Duals MCOs

- Beneficiary enrolled in MCO(s)
  - Medicaid: Mandatory
  - Medicare: Voluntary or passive
- Beneficiary must use MCO providers
- Full risk transfer via capitation
- Care coordination/ management emphasized

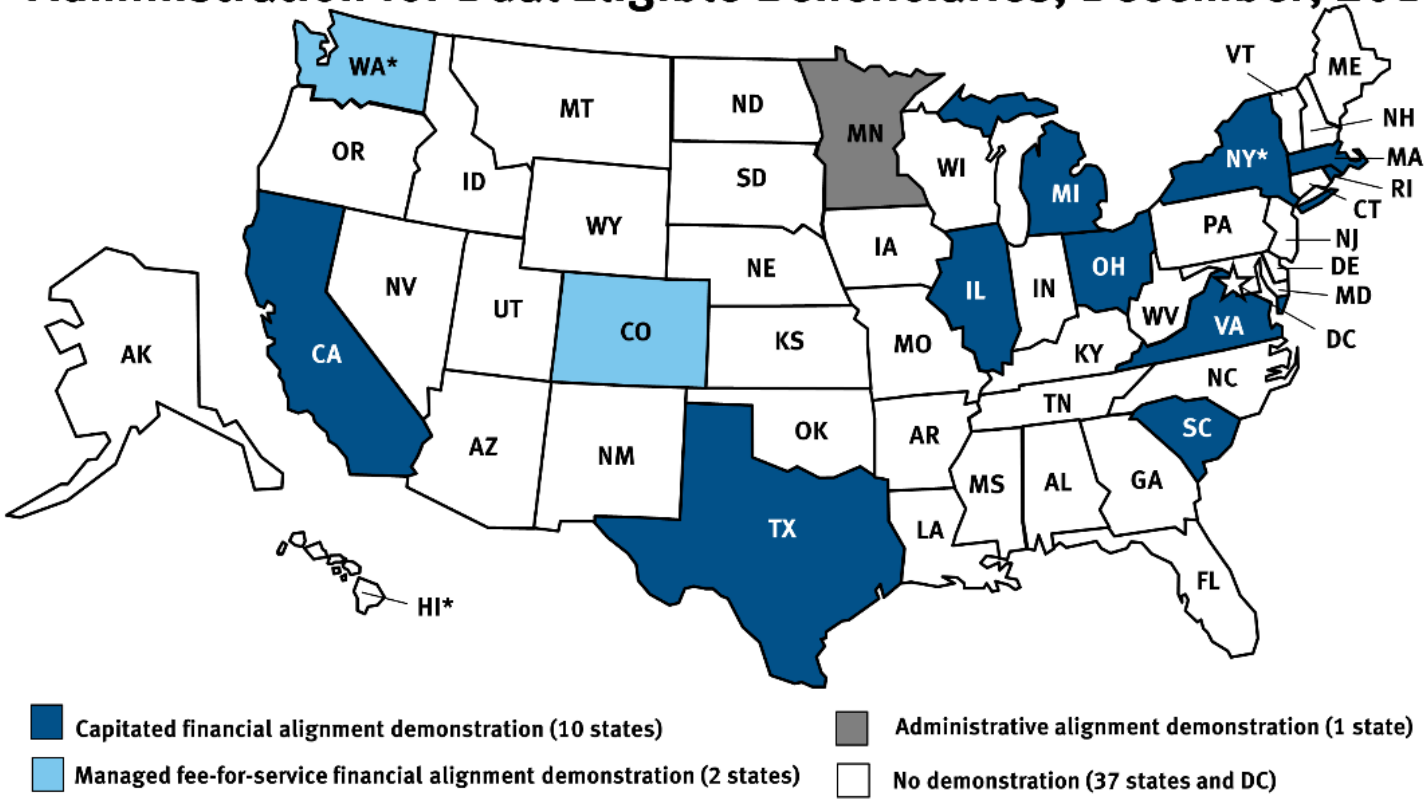
CLASSIFYING CMS AND STATE APPROACHES

Fee-for-Service/ Managed Care	Integrated Medicare & Medicaid Costs	Contracting Parties	Examples
FFS	Yes	Provider, State & CMS	Integrated ACO
		State & CMS	FFS Financial Alignment Demo
	No	Provider & State or CMS	MSSP, Pioneer, or Medicaid ACOs
		Provider & State	FFS Medicaid, State PCCM
MC	Yes	MCO, State, & CMS	Capitated Financial Alignment Demo, MLTC, PACE
	Minimal		Duals Special Needs Plan
	No	MCO & State or CMS	Medicaid Managed Care or Medicare Advantage
		TPA & State	Administrative Services Only

MLTC: Managed Long Term Care
MSSP: Medicare Shared Savings Program
PCCM: Primary Care Case Management

CURRENT DUALS DEMONSTRATION PROJECTS

State Demonstration Proposals to Align Financing and/or Administration for Dual Eligible Beneficiaries, December, 2015



NOTES: *WA received approval for two demonstrations, but subsequently withdrew its capitated model. NY withdrew its managed FFS proposal and has approval for 2 capitated demonstrations.
SOURCE: CMS Financial Alignment Initiative, State Financial Alignment Proposals and state websites.

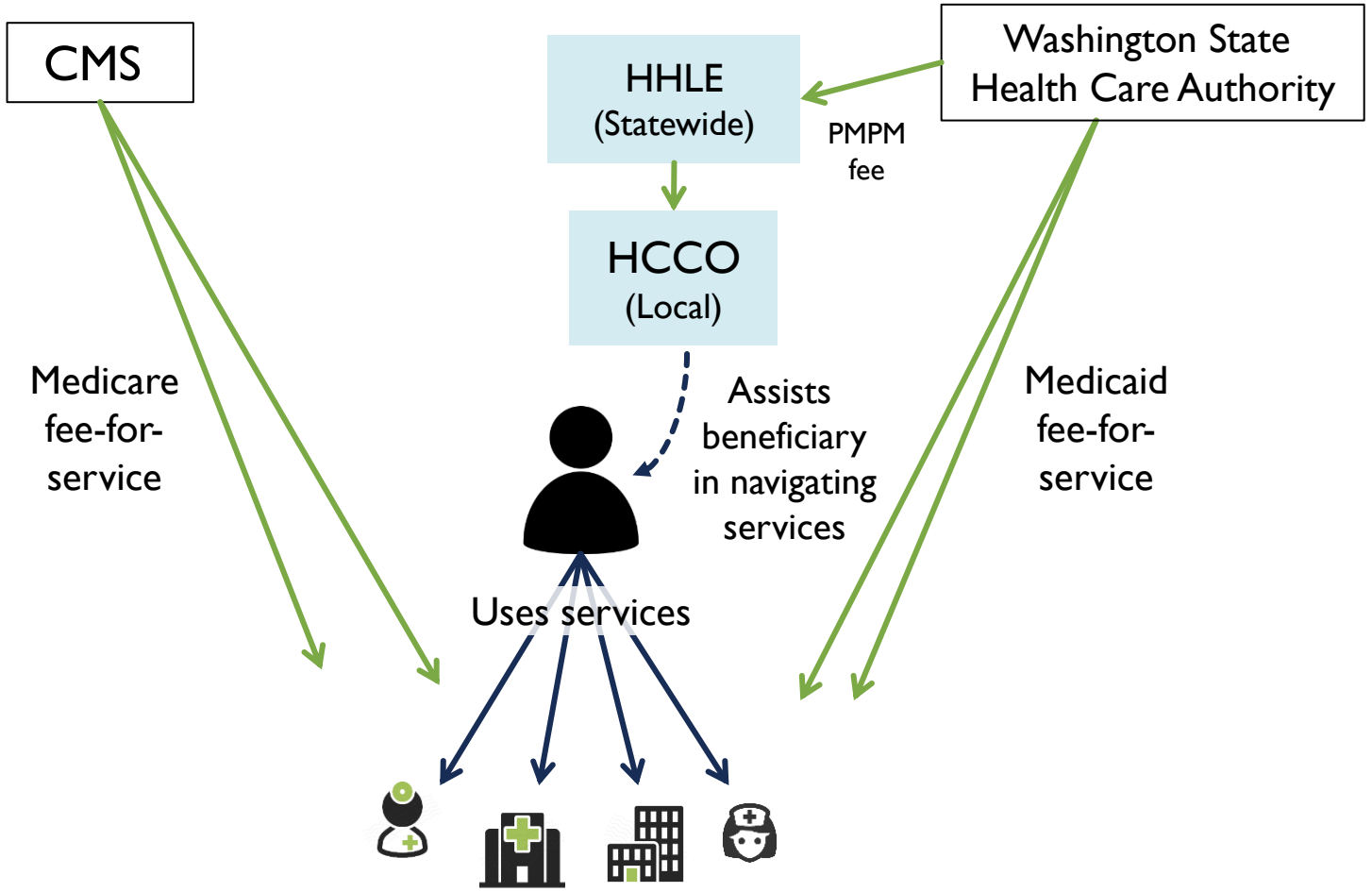
OVERVIEW OF 4 STATE MODELS

State	Aspects of Program of Interest for Maryland
Washington	• Managed FFS Duals Demonstration • Leverages Medicaid Health Homes • Care is coordinated through state-contracted entity • State & Medicare pay for care on standard FFS basis
Colorado	• Managed FFS Duals Demonstration • Passive enrollment • Contracted entity coordinates care
Florida	• Capitated MLTC MCO model • Built upon existing strong MCO model; 6 out of 17 Medicaid MCOs are integrated Medical/MLTC plans
Minnesota	• Demonstration of administrative alignment between Medicaid & Medicare • State duals integrated care model that utilizes existing D-SNP (Dual Eligible Special Needs Plan) presence

WASHINGTON: MANAGED FEE-FOR-SERVICE (1 OF 2)

- Passive enrollment with opt-out ; ~21,000 duals enrolled in MFFS Demo
- Seeks to improve the system by providing beneficiaries with the option to receive health home services
  - Demonstration does not change Medicare and Medicaid services beneficiaries are entitled to receive
- State contracts with a Health Home Lead Entity (HHLE) that subcontracts with Health Home Coordinated Care Organizations (HCCOs) to coordinate the health home services
  - HCCOs are paid per member per month (PMPM) rate for care coordination
- State/Medicare pays for care on FFS basis
- Shared savings opportunity: State may earn slice of Medicare savings

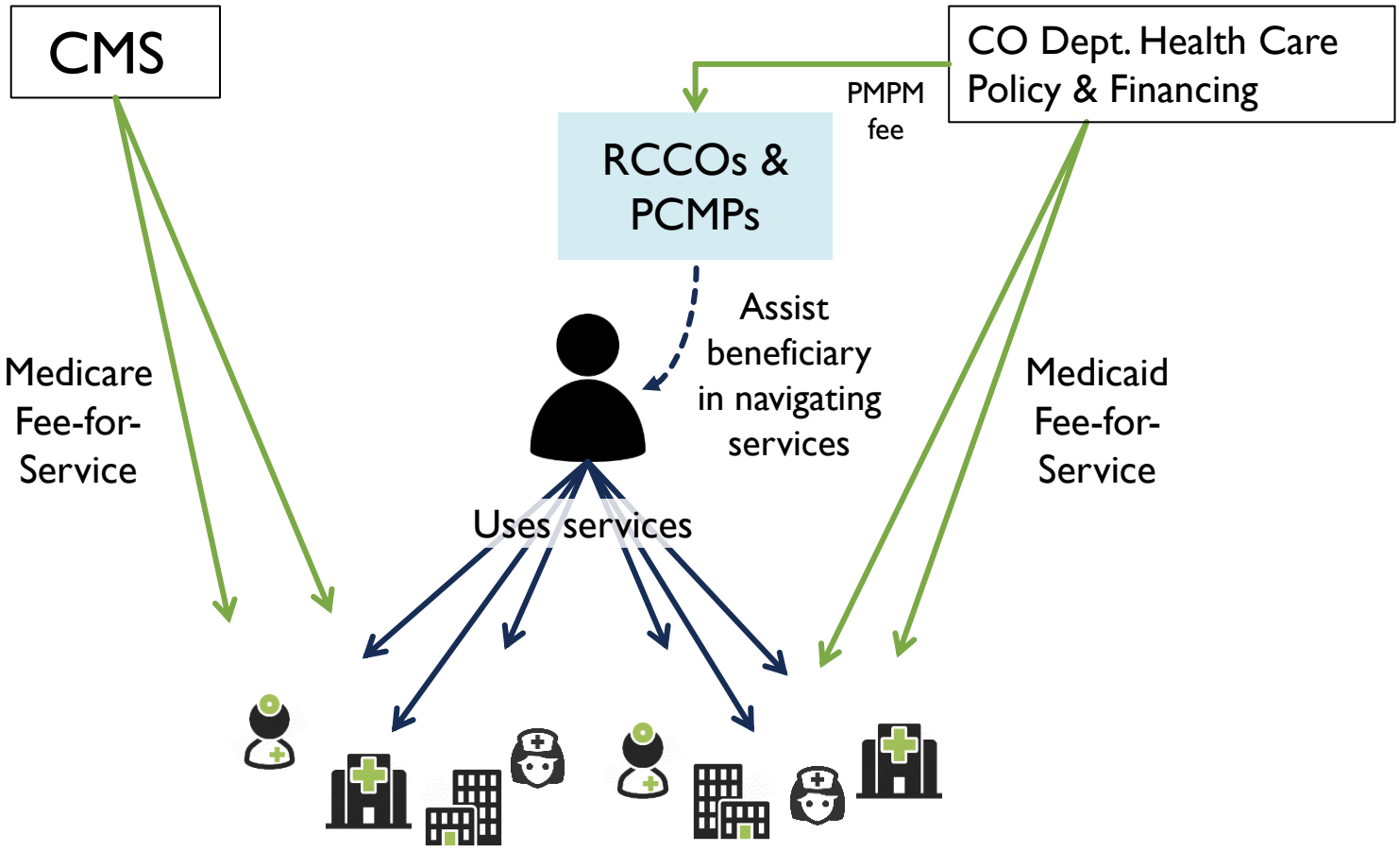
WASHINGTON: MANAGED FEE-FOR-SERVICE (2 OF 2)



COLORADO: MANAGED FEE-FOR-SERVICE (1 OF 2)

- Regional Care Collaborative Organizations (RCCO) and Primary Care Medical Providers (PCMP) help guide enrollees through care continuum
- Passive enrollment with opt-out
  - Fully dual eligible clients automatically enrolled into Accountable Care Collaborative (ACC) program but may choose another program if they wish
- Person-centered care; allows clients to keep their doctors and existing network of providers
- RCCO and PCMP prepare Service Coordination Plan: Completed with the client; documents medical, social, behavioral needs, plus short- and long-term goals
- RCCO facilitates cross-provider communication agreements: written agreements between inter-disciplinary providers describing process for identifying and working with clients

COLORADO: MANAGED FEE-FOR-SERVICE (2 OF 2)

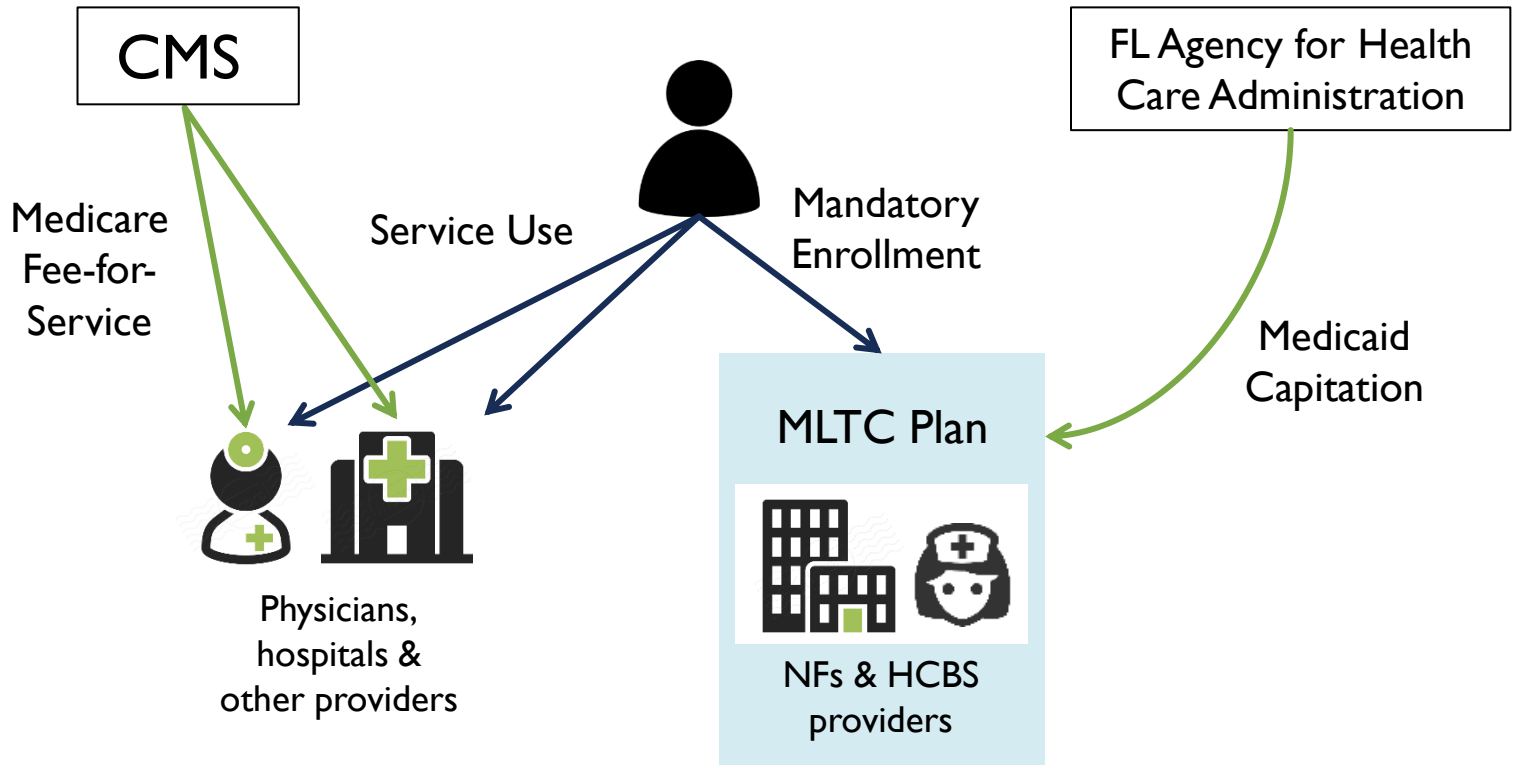


FLORIDA: MANAGED LONG-TERM CARE PROGRAM (1 OF 3)

- MLTC program provides long-term care services including nursing facility and home- and community-based services using a managed care model
- Mandatory enrollment with capitation payment
- Federal government pays for Medicare services via either
  - Fee-for-service, if beneficiary doesn't enroll in Medicare Advantage (MA), or
  - Capitation to Medicare Advantage Duals Special Needs Plans (D-SNP), if beneficiary has enrolled voluntarily
- MLTC plans coordinate with Medicare when able
  - State awarded more points in MLTC procurement process for plans that were also Medicare Advantage plans, to promote integration
  - Currently 6 MLTC contractors (out of 17 total Medicaid MCOs)
    - 4 of the 6 MLTC plans also have MA D-SNP contracts with CMS

FLORIDA: MANAGED LONG-TERM CARE PROGRAM (2 OF 3)

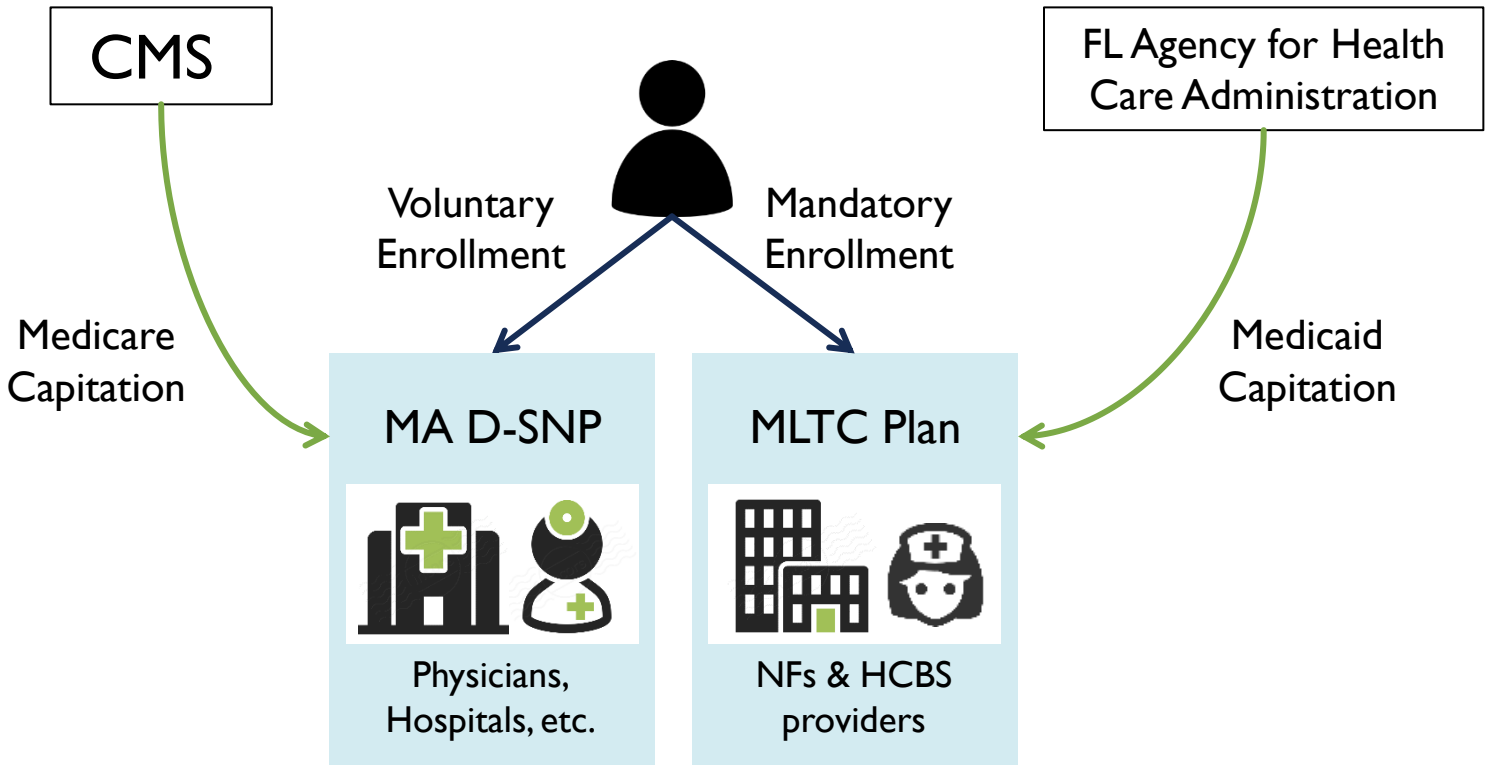
Beneficiary Elects Original (FFS) Medicare



NF: Nursing Facility
HCBS: Home- and Community-Based Services

FLORIDA: MANAGED LONG-TERM CARE PROGRAM (3 OF 3)

Beneficiary Enrolls in Medicare Advantage D-SNP

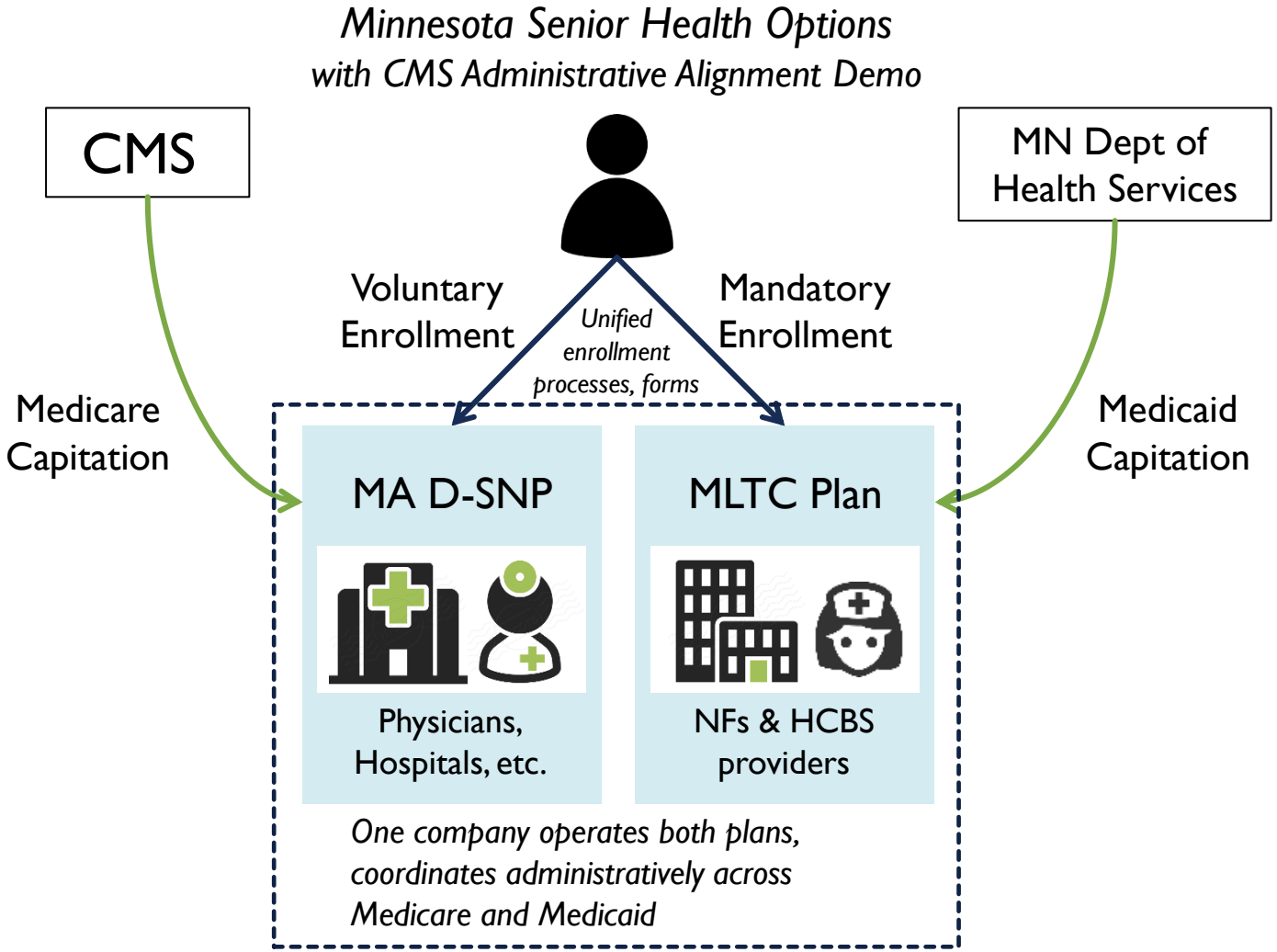


Opportunity for virtual integration if both plans sponsored by one company

MINNESOTA: MANAGED LONG-TERM CARE PROGRAM (1 OF 3)

- Minnesota operates 2 programs for senior duals:
  - **Minnesota Senior Care Plus (MSC+)** – Mandatory
    - Akin to Florida's MLTC program:
      - Medicaid via capitated MLTC plan
      - For Medicare, beneficiary chooses either original FFS Medicare or MA
  - **Minnesota Senior Health Options (MSHO)** – Voluntary
    - Capitated program including Medicaid and Medicare services for duals through integration with MA D-SNPs
    - 36,000 enrollees in 8 plans

MINNESOTA: MANAGED LONG-TERM CARE PROGRAM (2 OF 3)



MINNESOTA: MANAGED LONG-TERM CARE PROGRAM (3 OF 3)

- Administrative alignment demonstration enhances pre-existing MSHO program delivery system
  - Unifies, or at least aligns, member-facing communication, administrative aspects of enrollment, appeals and grievances
  - State and CMS will develop and test integrated Star measures (quality ratings)
  - State and CMS collaborating to unify beneficiary satisfaction (CAHPS) surveys
  - Aim to eliminate duplicate reporting requirements
- Payment model allows for integration
  - MSHO plans must bid on MA at a low enough level to allow $0 member premium
  - MSHO plans may process an integrated set of claims rather than differentiate Medicare from Medicaid services

LANDSCAPE & DESIGN CONSIDERATIONS

ALIGNING WITH CURRENT INITIATIVES, FRAMING NEW PROGRAM

LANDSCAPE DISCUSSION

- What are the existing efforts or programs surrounding the All-Payer Model that impact dual eligibles or could be leveraged in creating a solution for dual eligibles?

INITIAL DESIGN CONSIDERATIONS

- Should the new program encompass all full duals (other than DD) or should it focus on subsets such as (a) those requiring LTSS or (b) those exhibiting highest need or highest risk?
- Will the program encompass all Medicare and Medicaid benefits and services or will some be carved out?
- Is the best design closest to (a) Managed Fee-for-Service, (b) ACO, (c) MCO?
- If ACO or MCO, how much risk should the State shift to program participants?
- Should the program run statewide or in limited areas? If statewide, should it be operated statewide or divided regionally?
- Who will be the contracting parties? What is the role of each party?
- Should an umbrella organization govern/facilitate the operations of the program?
- How will duals care delivery integrate with Maryland's All-Payer Model?
- How do we define quality? What are our measures of success regarding full duals?

DUALS CARE DELIVERY WORKGROUP MEETINGS

Meeting	Subject Matter and Goals
Apr 4	• Present and discuss vision for a duals care coordination program encompassing delivery organization, payment, quality concepts, and information infrastructure (to include options that do and don't include hospital services affected by All-Payer Model)
May 2	• Discuss refined program concept reflecting feedback from Apr 4 meeting • Explain any waivers needed to implement program
Jun 1	• Present final program concept for • Describe key elements of any waiver application
Jun 29	• Further discuss any waiver application